COB Contractor MSP Claims Investigation Fact Sheet for Providers

The Coordination of Benefits Contractor (COBC) initiates a Medicare Secondary Payer (MSP) investigation when it learns that a beneficiary has other insurance. The purpose of this investigation is to determine whether Medicare or the other insurance has primary responsibility for meeting the beneficiary's health care costs. This process involves developing additional information related to the beneficiary's health benefit coverage and resolving any conflicts in the information to ensure Medicare pays only what it is obligated to pay.

The goal of these MSP information-gathering activities is to identify MSP situations rapidly, thus ensuring correct primary and secondary payments by the responsible parties. Providers, physicians, and other suppliers benefit from these activities because the total payments received for services provided to Medicare beneficiaries are greater when Medicare is a secondary payer to a group health plan (GHP) than when Medicare is the primary payer.

MSP Claims Investigation

First Claim Development

The First Claim Development (FCD) process is one of several MSP information-gathering activities that is conducted by the COBC. When a Medicare beneficiary receives medical services for the first time, the claim is submitted to a Medicare intermediary or carrier for payment. Medicare reviews the beneficiary's file to determine if there is other insurance information that may pay before Medicare. If Medicare does not have such information, the Medicare intermediary or carrier receiving the first claim processes the claim for primary payment, and the COBC generates an MSP development questionnaire to the provider of service.

A Medicare provider, whether a physician, non-physician practitioner, laboratory, or other supplier (durable medical equipment supplier, etc.), is required to indicate if there is other insurance that may be primary to Medicare when submitting a Medicare claim for payment. If Medicare has no record of other insurance that may be secondary to Medicare, the provider may be asked to complete an FCD Questionnaire.

How to Complete the FCD Questionnaire

There are three types of FCD questionnaires:

1. Questionnaire A is for individuals entitled to Medicare based upon age (65 or older).
2. Questionnaire B is for individuals entitled to Medicare due to End Stage Renal Disease (ESRD).
3. Questionnaire C is for individuals entitled to Medicare due to disability.

The provider will be supplied with the name and Health Insurance Claim Number (HICN) of each individual for whom the provider is required to furnish the requested information. Each questionnaire will contain three parts with multiple questions. Below is a sample of the information requested for an individual entitled to Medicare based on age.

Part I – Information about the Patient

Question #1 – *Does the patient have any group health coverage based upon his/her current employment?*
If the patient is currently employed and has GHP coverage from their current employer, place an "X" in the YES box and proceed to Question #2. If the answer to #1 is NO, place an "X" in the NO box then go to Part II.

Question #2 – *How many employees, including the patient, work for the employer from whom the patient has health insurance?*
Enter an "X" in the 1-19 box if the patient's employer has less than 19 full or part-time employees. If the employer has more than 20 or more individuals and the answer to Question #1 is YES, Medicare is the secondary payer. Collect and submit the patient's employer and insurance information in the space provided.

Note: The date the insurance coverage began is the month, day, and calendar year (MM/DD/CCYY) the employer group health plan (EGHP) coverage went into effect. The policy number is also known as the plan identification number. Place an "X" in the appropriate box if the insurance coverage only applies to either medical services or hospital services. Otherwise, place an "X" in the hospital and medical box.

Part II – More Information about the Patient

Question #1 – *Is the patient receiving Black Lung benefits?*
Answer either YES or NO. If yes, you will have to provide the date (MM/DD/CCYY) benefits began. The Federal Coal Mine Health and Safety Act of 1969 created the Federal Black Lung Program. This Federal program provides workers' compensation (WC) protection for federal civil service employees and certain other categories of employees not covered or not adequately covered under state WC programs; e.g., coal miners totally disabled due to pneumoconiosis.

Note: A Medicare beneficiary may be entitled to have the services reimbursed by the Department of Labor (DOL) under the Federal Black Lung Program (e.g., bill DOL). However, if the services rendered a black lung beneficiary were solely for a non-black lung condition (e.g., diabetes, a fracture), the provider must bill the Medicare carrier. It is the responsibility of the provider to identify beneficiaries who may be entitled to benefits under the Federal Black Lung Program. These will generally be cases in which the beneficiary or his or her representative states he or she is entitled to black lung medical benefits.

Question #2 – *Is the patient receiving workers' compensation benefits?*
If the patient is receiving workers' compensation (WC) benefits, enter an "X" in the YES box then provide the date (MM/DD/CCYY) benefits began. If WC benefits are not in effect, enter an "X" in the NO box. Please note payment under Medicare may not be made for any items or services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or any state.

Question #3 – *Is the patient receiving treatment for an injury or illness for which another party could be held liable or that is covered under automobile no-fault insurance?*
Please answer either YES or NO if the patient is receiving treatment for an injury or illness for which another party could be held liable or that is covered under automobile no-fault insurance. If yes, provide the date benefits began.

Note: Medicare is secondary to no-fault insurance even if state law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. If services are covered under no-fault insurance, that insurer must be billed first. If the insurance does not pay all the charges, a claim for secondary Medicare benefits can be submitted to supplement the amount paid by the insurer. Medicare can pay for services related to an accident if benefits are not currently available under the individual's no-fault insurance coverage because that insurance has paid maximum benefits for the accident or items. If the answer is YES to any of the questions in Part II, Medicare may be the secondary payer. Collect and submit the patient's insurance, employer, and attorney information and provide a brief description of the illness or injury relating to the accident.

Part III – Information about the Patient's Spouse

Question #1 – *Does the patient have any group health plan coverage based upon his/her spouse's current employment?*
If the patient's spouse is currently employed and has insurance from the current employer that provides health care for the patient, place an "X" in the YES box then continue on to Question #2. If the answer to Question #1 is NO, place an "X" in the NO box, sign the form, and mail it to the COBC in the self-addressed envelope provided.

Question #2 – *How many employees, including the patient's spouse, work for the employer from whom the patient has health insurance?*
If the spouse's employer employs 20 or more employees, enter an "X" in the box marked "20 or more." If the employer employs less than 20 employees, enter an "X" in the box marked "1-19."

Note: If the answers to questions 1 and 2 are YES, Medicare is the secondary payer. Therefore, you must collect and submit information on the spouse's employer and group health plan. The date the insurance coverage began is the month, day, and calendar year (MM/DD/CCYY) the EGHP coverage went into effect. The policy number is also known as the plan identification number. Place an "X" in the appropriate box if the

insurance coverage only applies to either medical services or hospital services. Otherwise, place an "X" in the hospital and medical box.

Trauma Code Development

Trauma/injury diagnosis codes submitted on a Medicare claim will alert the COBC that an accident or traumatic injury may have occurred, and the possibility of an MSP situation warrants development. This process is known as **Trauma Code Development (TCD**).

In situations where the medical services are related to a workers' compensation injury, automobile accident, or other liability, another payer has the primary responsibility for payment of medical claims related to the injury. When the possibility of a liability situation arises to the extent that payment has been made or can reasonably be expected to be made by another liable party, and the Medicare claim submitted does not contain pertinent information about the other payer, a development questionnaire is issued. Payment may not be made under Medicare when payment has been made or can reasonably be expected to be made promptly (120 days) for covered items or services under any no-fault insurance (including a self-insured plan). Medicare is secondary to no-fault insurance even if state law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. If Medicare payments have been made but should not have been, or if the payments were made on a conditional basis, they are subject to recovery. If an MSP liability situation is identified after the Medicare claim is paid primary, you may be required to reimburse Medicare. The claim may be reprocessed or adjusted to reflect Medicare as the secondary payer.

A properly filed claim prevents the need for follow-up development and expedites the payment process. In these situations, it is important to include the date of incident and the insurance carrier's name, address, and policy number on the Medicare claim.

The Provider's Role in Data Gathering

Prior to billing Medicare, providers must ensure that they are billing the correct primary payer. A few minutes during each visit can later save time and money. When collecting this data, the provider must indicate if the health care coverage is due to retirement and a supplemental policy.

A sample of the kind of questions a provider should ask are listed below:

- Does the patient have any group health plan (GHP) coverage based upon his/her current employment? (Medigap coverage should not be indicated.)
- Does the patient have any GHP coverage based upon his/her former employment?
- How many employees, including the patient, work for the employer from whom the patient has health insurance?

- Does the patient have any GHP coverage based upon his/her spouse's or another family member's current employment?
- Does the patient have any GHP coverage based upon his/her spouse's or another family member's former employment?
- How many employees, including the patient's spouse or other family members, work for the employer from whom the patient has health insurance?
- Is the patient receiving Black Lung benefits?
- Is the patient receiving workers' compensation benefits?
- Is the patient receiving treatment for an injury or illness for which another party could be held liable or is covered under automobile no-fault insurance?

The answers to these questions will assist you with completing a beneficiary's claim and submitting it to the correct primary payer. It is important that the questionnaire be completed in its entirety and in the exact format of the questionnaire.

Contacting the COBC

Questions regarding the First Claim Development process and all other MSP Claims Investigation processes should be directed to the COBC. Please call the COBC's Customer Service Department toll-free at 1-800-999-1118 or TTY/TDD: 1-800-318-8782 for the hearing and speech impaired. Customer Service Representatives are available to assist you from 8 a.m. to 8 p.m., Monday through Friday, Eastern Time, except holidays. Providers must identify themselves by supplying the representative with a valid UPIN, OSCAR, or NSC number. This ensures the privacy of the beneficiary's information. The mailing address for written inquiries is indicated below. Please visit the COBC's Web site at http://www.hcfa.gov/medicare/cob for more information regarding the COBC and the MSP Claims Investigation Project.

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